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ABSTRACT

A recent review of published and unpublished data suggests that the elderly are underrepresented in most self-help groups. Some national groups, such as Alcoholics Anonymous do serve the aged but many others such as widow groups do not. A recent national survey of over 3,000 households conducted by Mellinger and Balter examined the use of psychotropic medication and the help-seeking patterns of troubled respondents. A secondary analysis of the Mellinger-Balter data was conducted to examine patterns of participation in self-help groups by the elderly, the effectiveness of self-help groups, and the differential patterns of participation based on problem or disease to determine what types of groups are most successful in serving the elderly. Critical policy issues raised by these analyses involve the following: (1) the relative value of age-homogeneous groups when compared with age-heterogeneous groups; (2) the best forms of legitimization of self-help groups; and (3) the role of the professional service system. These findings have implications for the different strategies of generating and maintaining self-help groups including professional transfer models, financial aid, and consultation models. A reference list and 15 data tables are appended. (Author/ABL)

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SELF-HELP GROUPS -- IMPLICATIONS FOR THE ELDERLY

Literature Synthesis and Secondary Analysis of
National Data on Use of Mental Health Services

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The designation "self-help group" is commonly applied to a wide variety of activities. Killilea's (1976) extensive review indicates that self-help groups (SHGs) are described as support systems, social movements, spiritual movements and secular religions, systems of consumer participation, alternative care-giving systems adjunct to professional helping systems, intentional communities, subcultural entities that represent a way of life, supplementary communities, expressive-social influence groups, and organizations of the deviant and stigmatized. The diversity of activities in this society that have received the self-help label suggests, on one hand, their vigor, and on the other hand, the absence of the conceptual clarity required for their scientific study.

Of special interest here are SHGs that serve populations requiring or desiring mental health services, including individuals in emotional distress associated with physical conditions, stigmatized roles in society, difficulties in the normal transitions of the life cycle, or dilemmas arising from the variety of stresses and strains that characterize modern society.

The purpose of this report is to systematically examine the role and place of SHGs in providing services for the elderly that are, all too frequently, a variety of SHGs with a primary function of political and/or social change.

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For the purposes of this report, the SHG is defined as being composed of members who share a common condition, situation, heritage, symptom, or experience. The groups are largely self-governing and self-regulating. They emphasize self-reliance and generally offer a face-to-face or phone-to-phone fellowship network, available and accessible without charge. They tend to be self-supporting rather than dependent on external funding. Within this general definition, those that are of relevance to mental health professionals have been classified by Levy (1979) on the basis of their composition and purpose:

- 1) Behavioral control or conduct reorganization groups are composed of members who are in agreement in their desire to eliminate or control some problematic behavior. The activities of these groups have as their sole purpose helping their members control the problematic behavior common to them, and these groups often refuse to deal with any other concerns or problems of their members. Alcoholics Anonymous, Gamblers Anonymous, Overeaters Anonymous, Parents Anonymous, and Take Off Pounds Sensibly are examples of this type.
- 2) Stress coping and support groups are composed of members who share a common status or predicament that entails some degree of stress. The aim of such groups is to ameliorate the stress through mutual support and the sharing of coping strategies and advice. There is no attempt to change their members' status, which is taken as fixed. The problem for members of these groups is how to carry on in spite of it. Groups representative of this type are Al-Anon, Emotions Anonymous, Make Today Count, Parents Without Partners, Recovery, Inc., Theos, Compassionate Friends, and

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Parenting Groups.

- 3) Survival oriented groups are composed of people whom society has either labeled or discriminated against because of their life-style and values or on other grounds such as sex, sexual orientation, socioeconomic class, or race. These groups are concerned with helping their members maintain or enhance their self-esteem through mutual support and consciousness-raising activities, and with bettering their lot by gaining legitimacy for their style of life and eliminating the grounds on which they have been stigmatized and discriminated against. Examples of this type are Women's Consciousness-Raising groups and Gay Rights.
- 4) Personal growth and self-actualization groups are made up of members who share the common goal of enhanced effectiveness in all aspects of their lives, particularly those involving their emotionality, sexuality, and capacity to relate to others. In contrast to other types of groups, there is no core problem that brings members of these groups together; instead, there is the shared belief that together they can help each other improve the quality of their lives. Examples of this type are Integrity Groups and SAGE (Senior Actualization Growth Encounter).

RESEARCH SYNTHESIS AND CRITIQUE

DEVELOPMENT AND ORIGINS

Although the use of groups by mental health practitioners for aiding people in distress is of relatively recent origin, small groups have served as

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important healing agents from the beginning of recorded history. Group forces have been used to inspire hope, increase morale, offer strong emotional support, induce serenity and confidence, or counteract psychic and bodily ills. Religious healers have always relied heavily on group forces, but when healing passed from the priestly to the medical profession, deliberate use of group forces fell into decline until post-World War II. Although it is not difficult to find surface similarities between some SHGs and professionally conducted psychotherapy groups, it should be stated at the onset that the origins of groups as they are currently utilized in psychiatry and the vast majority of SHGs have distinctive historical roots. An examination of the published scholarship on the history of SHGs reveals a number of different perspectives, in part based upon the level of analysis, and the scope of historical time considered. Some authors (Katz & Bender, 1976) focus on the origins of SHGs in Anglo-Saxon society, seeing the development of Friendly societies in the 18th century as a parallel to current SHGs. Other scholars (Hurvitz, 1976) trace the recent history, focusing on such groups as Alcoholics Anonymous, Recovery, Inc., Synanon, and others of quasi-psychotherapeutic concern to the U.S. protestant tradition, combined with a secular democratic-populist philosophy. Tax (1976), an anthropologist, describes the emergence of "ad-hoc" mutual aid groups that contrasted with traditional protective groups like the family, the tribe, and the village. He analyzes their history on the basis of long-term historical trends of how societies have developed affiliative arrangements beyond those with kith and kin. Collectively, these perspectives serve to underscore the diverse origins and conceptual framework applied to SHGs.

The most common explanatory model to account for the current development

of SHGs is based upon a functionalist framework, which sees new institutions arising in society when there are meaningful and recognized needs that are not being met for members of that society by existing institutions. This functionalist view accounts for the emergence of SHGs where unmet needs apparently "fall between the cracks" of available services. Examples are plentiful. The inadequate professional response to problems of alcoholism is proffered as the classical example. The recent development of SHGs for chronic medical conditions, despite the proliferation of professional rehabilitation services, is seen by some (Tracy & Gussow, 1976) as an indicator of the inadequacy of professional institutions to meet such needs.

In contrast to the functionalist view is the explanation of alternative pathways in which members of society obtain services already acknowledged in the programs of other institutions in that society. Here the emphasis is not so much on the unmet need as on the incorrectly or inadequately met need; the focus is on the form through which the service is offered. Such explanations usually reflect broad social shifts in values, for example, towards increasing democratization and egalitarianism of membership.

Still another view is that the growth and development of such institutions is best explained by individual needs for affiliation and community with others in similar conditions. Here again the emphasis is on unmet needs but of a different kind than those addressed by the group's function. For many in modern western society, traditional affiliative bonds that might exist through professional societies, labor unions, and such are limited or decreasing to a point where new foci of affiliation are required. Such a perspective raises the question of what about our current society makes

appropriate such fundamental bonding of adults faced with common afflictions or patterns of deviance.

These broad explanations, when applied to specific a SHG, may or may not match well. Obviously, no simple or single explanatory model will fit the polyglot phenomena represented in the SHG movement.

THE SCOPE OF SELF-HELP GROUPS

Until quite recently, reliable information on the numbers of such groups and of the participants in them has been difficult to ascertain. Tracy and Gussow (1976) have provided information on the growth rate of a number of national groups -- International Association of Laryngectomees, Recovery, Inc., International Parents Organization, United Ostomy Clubs, Gamblers Anonymous, ANON, Parents Anonymous, and Alcoholics Anonymous. Their data appear to support a yearly 3 percent growth rate in numbers of chapters so that, for example, in 1960 there were 500 chapters of the SHGs studied excluding Alcoholics Anonymous, and by 1972 there were over 2,000. Similar figures for Alcoholics Anonymous indicate that in 1960 there were more than 8,000 chapters. Such information provides a perspective on the growth rate of nationally organized SHGs. It does not, of course, reflect the diversity of loosely affiliated or nonaffiliated local groups.

Another index of the diversity and magnitude of SHGs is provided by the information made available by a relatively new structure related to SHGs -- self-help clearinghouses or information exchanges. Often such centers are funded through state agencies combined with voluntary sectors of society and

serve to provide for exchange among SHGs as well as information to prospective participants. Some centers provide consultation to ongoing SHGs and are engaged in the development of new groups. The Self-Help Center of Evanston, Illinois publishes (as many others do) a listing of active SHGS within the metropolitan area. The 1981-82 directory has 320 organizations listed. They range from well-known organizations representing a number of local chapters, such as Alcoholics Anonymous, to small one- or two-chapter organizations, such as All but Dissertation self-help groups. The breadth and diversity of problems these groups address is indeed astonishing -- almost all chronic diseases are represented as are psychiatric conditions such as agoraphobia, depression, epilepsy, families of suicide victims, a variety of neurological diseases, eating disorders. Groups also address a multitude of serious emotional crises brought on by expected as well as unexpected life events -- retirement, widowhood, loss of a child, various illnesses or handicaps of children, unemployment, and divorce. The range of afflictions represented by SHGs is indeed broad and appears to be increasing exponentially. Almost any definable problem brought about by physical and emotional health concerns, as well as stigmatized conditions and feelings of deviance to the larger society, provides a nexus for SHG formation.

Results from a recent national survey based on a national probability sample of over 3,000 households (Mellinger & Balter, 1983) permit precision about the prevalence and utilization of SHGs. Their study was directed primarily towards examining the use of psychotropic medication, but inquired into the help-seeking patterns of troubled respondents. One-year prevalence rates of all individuals using mental health professionals was 5.6 percent; 5 percent used clergy or pastoral sources, and 5.8 percent utilized SHGs of

varying kinds. These findings suggest that mutual aid groups are a major and growing source of therapeutic treatment for a variety of physical and emotional difficulties, and support with empirical fact the estimates that from 12 to 14 million adult Americans utilize such groups.

No reliable information on the participation of the elderly in SHGs has existed until now. Most estimates suggested that the elderly are underrepresented to about the same extent in mutual aid groups as they are in other forms of psychological services. Lieberman and Borman's (1979) series of studies found that widows over 60 represent 20 percent of national SHGs, less than expected using demographic projections on widowhood. They also reported that participants over 60 in Mended Hearts, a group dealing with the emotional and physical sequelae of open-heart surgery, represent 40 percent of the membership -- again, less than expected based on the demographics of open-heart surgery. In contrast, Borkman's (1982) review of the published literature suggested that for some problem areas -- e.g., alcoholism -- elderly participation reflects accurately the frequency of the disorder.

A secondary analysis of the Mellinger-Balter data, done for this report, examines the relationship between use of SHGs and several social and psychological factors. To place changed use with age in a context, SHG prevalence is compared to professional mental health services (PMHSs). Overall, until 65, approximately 80 percent of the population during the 1979 year were not involved in any form of psychosocial treatment; the percentage of non-users jumped to 91 percent in the 65 to 79 age range. The overall drop-off rate between middle life (age 50-64) and the elderly for all other forms of psychosocial treatment excluding SHG was 30 percent; for the clergy,

the drop-off rate was 25 percent. The drop-off rate for self-help was 72 percent. This indicates that although, overall, the use of psychosocial treatments declines with age, the drop-off is even greater for SHGs.

What factors may explain the sharp decrease? Is the elderly's lower-than-expected participation in SHGs based on their use of alternative support systems? Two forms of social support were examined -- instrumental and emotional. Of the entire study population, 3.2 percent had no one they could turn to for instrumental support when they were sick. An age analysis indicates that there is a linear increase so that at the youngest age group, only .8 percent have no one they can count on, while 5.6 percent of the elderly have no one to turn to. The elderly's size of social network (number of people) for instrumental support is also smaller than that of younger age groups. For emotional support, there is a similar linear characterization -- 9.1 percent of the entire population report no confidante, ranging from a low of 4.2 percent for the youngest group to 16 percent for the elderly. In addition, the elderly's emotional networks are the smallest. Thus, the finding that the elderly underutilize SHGs could not be accounted for by the use of alternative social networks.

Inasmuch as many SHGs are directed towards individuals with physical health problems, and that studies have repeatedly found that health problems increase with age (as they do in the current survey [see Table 6]), the relationship between health problems and utilization of PMHSs and SHGs was explored. There is a strong relationship between utilization of psychosocial therapy and health problems, with increasing severity of health problems associated with higher proportions of individuals using PMHSs. Two-thirds of

the sample had few or no health problems and of that group, only 16 percent are PMHS users. For those with two or more health problems, 65 percent are PMHS users. In contrast, 32 percent use SHGs (39%, Behavioral; 20%, Support; and 30%, Growth). Health problems predict the use of PMHSs more strongly than the use of SHGs.

A number of studies have found that current life stress predicts the utilization of health services. The present study shows that the use of PMHSs increases linearly with increasing life event scores. Thus, 2.3 percent of those with low life stress utilize PMHSs, while 12.1 percent of those with high life stress do so. A similar observation is characteristic of SHGs -- low life stress, 2.9 percent, and high life stress, 11.0 percent. An analysis of the type of SHG suggests that high life stress is most related to participation in growth-oriented groups (43% in growth groups, 36% in support groups, and 29% in behavioral groups had high life stress). Overall, stressful life events are linked to utilization of services. However, this is less true for SHGs, particularly behavioral groups.

There is a strong relationship between level of life stress and age, a finding that has been reported in numerous studies. High life stress is most characteristic of the younger age groups (18-34), and decreases linearly with increasing age so that for those aged 65-79, only 3.4 percent report high life stress, compared to over 30 percent of those in the 18-34 age range. The extent to which this explains the decrements in participation in SHGs by the elderly is unknown. We believe that the effect is negligible because low life event scores (the measure of life stress) are to some extent artifactual, since life stress measures are role contingent and are thus a biased

assessment of the elderly.

Using the Hopkins Symptom Checklist, a strong relationship between level of psychic distress and utilization of PMHSs from a low of 2.6 percent for those in low distress to a high of 10.3 percent for those in high distress was found. This relationship is not of the same magnitude for the utilization of SHGs, which overall show 4.1 percent of those with low psychic distress using SHGs to 8.4 percent of those with high psychic distress (a doubling rather than quadrupling). Overall, there is a greater percentage of individuals in SHGs who have low psychic distress. Of the total population, 71 percent has relatively low psychic distress. It was found that 65 percent of the people in behavioral SHGs have low distress; 61 percent of those in support groups have low distress, and 57 percent of those in growth groups have low distress. In comparison, only 47 percent of PMHS users have low psychic distress. Or conversely, 30 percent of the population that is high stress accounts for 54 percent of PMHS users, 43 percent of the growth SHG users, 40 percent of the support SHG users, and 35 percent of the behavioral SHG users.

Overall, level of psychic distress is not highly age-linked. There is the slight tendency for the elderly to report somewhat less psychic distress -- 36 percent of the 18-24 group report high distress; 34 percent of the 25-34 groups; 26 percent of the 35-49 group; 27 percent of the 50-64 group; and 22 percent of the 65-79 age group. In general, the sharp drop-off in utilization of SHGs is unlikely to be explained by the elderly's lower psychic distress since a) psychic distress is not highly related to utilization of SHGs as compared to use of PMHSs, and b) the degree of linkage with age exists but is not overly high.

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There is a strong and substantial relationship of role impairment due to emotional causes and utilization of PMHSs. Although only 9 percent of the adult population suffers serious role impairment (couldn't keep up or cut back through 2 or more weeks during the past year), the proportion was 33 percent using PMHSs and 25 percent using clergy, while only 13 percent used SHGs. Of interest is that role impairment not associated with emotional problems is more characteristic of SHG use than it is of PMHS use (37% of those who used behavioral SHGs, 47% of those who used support groups, and 56% of those who used growth groups had nonpsychological role impairment). In general, those who used SHGs were either non-role impaired or role impaired because of nonpsychological factors, and few who were role impaired on the basis of psychological factors found their way into SHGs. Thus, for example, 77 percent of those who used behavioral SHGs were in the category of no role impairment or nonpsychological role impairment; 82 percent of those who used support groups were similar; and 87 percent of those who used growth groups were similar. In conclusion, role impairment, although predicting usage of PMHSs, does not predict those who use SHGs. Role impairment due to emotional causes is strongly linked to age, with the elderly showing less role impairment than younger individuals. The percentage of nonimpaired was 47 percent of the youngest groups, 43 percent of those in the 25-34 groups, increased to 50 percent of the 35-49 groups, 63 percent of the 50-64, and 72 percent of the aged. Role impairment associated with nonpsychological causes showed a similar pattern but is less marked.

Overall, the factors that are linked to the utilization of PMHSs, particularly measures of psychic distress or poor functioning, are not strong

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predictors in general of the use of SHGs. Although they show strong age trends, they would appear not to account for the lowered utilization of SHGs by the elderly although they may account for the decrease in use of professional services. The only factor that appears to be implicated in influencing the use of psychosocial treatment and SHGs is life stress in which there is a strong age finding. However, this could be the result of an artifact of measurement.

OUTCOME STUDIES

Self-help groups will merit the serious attention of mental health professionals, in large part to the extent to which their "services" can be shown to perform based on empirical criteria of importance to the field. This section's emphasis is on empirical studies that resemble the standard canons of traditional psychotherapeutic outcome research. Although there is interest by mental health professionals in the SHG contribution to primary prevention, no evaluation research is available that demonstrates their impact on prevention. Empirical research on outcomes is limited, and, by and large, covers a narrow band of activities. Studies of behavioral deviations -- alcoholism, overeating, and drug abuse -- predominate. Rare are studies of groups dealing with various life transitions or crises and major mental disorders of central concern to mental health. Compared to the relative sophistication and frequency of empirical studies on psychotherapy, the number and quality of studies available for assessing the effects of SHGs resembles the status of psychotherapy research in the 1950s.

Clinical-descriptive studies are far more numerous than more rigorous

quasi-experimental or experimental designs. The special dilemmas facing investigators in designing self-help outcome research probably contributes to the scarcity of well-controlled studies. SHGs, in contrast to settings for psychotherapy, are not under the control of the investigator. The values inherent in self-help and their community base frequently make it difficult to design research meeting current standards of psychotherapy evaluation. To cite but one example, the problem of randomization is relatively unsolvable; the methods that SHGs use to recruit their members would make the usual design requirements for random assignment, alternate treatments, or delayed treatment controls logistically difficult. The few experimental studies that exist on SHGs (for example, Farash, 1979; Gates, 1980; Gordon, Edmunson, Bedell, & Goldstein, 1979; and Gould, Garrigues & Scheikowitz, 1975) represent self-help in name only, since they are frequently controlled by professionals, are of brief duration, and do not represent some of the essential characteristics of SHGs. The best research in this area represents quasi-experimental designs, using contrast group designs, occasionally those of alternative treatment, but, more frequently, untreated cohorts of the similarly afflicted who had access to self-help. Large sample methods, using statistical controls, characterize recent attempts to solve some of the control issues.

Beyond such research design issues are questions of how to address the classic issues found in psychotherapy outcome research -- who to measure, when to measure, and what to measure. Traditional criteria evaluating mental health status have been used by some self-help researchers. It is, however, recognized that for many SHGs, the designations of illness, or its absence, are different from those of traditional mental health perspectives. For example, in a study of women's consciousness-raising groups (Lieberman and

Rond, 1976), evidence was gathered that, on one hand, the majority of women entering such groups could be characterized as having clinically relevant depression, and that participation in groups was linked to a lessening of symptoms. Beyond the simple measure, however, was a finding that participants in consciousness-raising groups systematically increased in their view of themselves as being stigmatized by society. Such an attitude would not be seen by the professional community as reflecting positive mental health, but was viewed by the groups as positive and fitting with their ideological perspective. That the views held by SHGs are often at variance with predominant health perspectives is illustrated by the oft-quoted critique of Recovery Incorporated as encouraging denial of illness. From the perspective of the group, such behavior is fundamental to their ideology and to the processes in which they attempt to affect people. The criteria mental health researchers can use to evaluate the impact of SHGs can, at times, dovetail with those commonly employed to evaluate outcomes. More frequently, however, such criteria ignore important functions of the group. Required are alternative perspectives as well as a recognition of the relativity of a professional view of good functioning.

Traditional psychotherapeutic systems are generally temporary, and evaluation procedures are based on the expectation that people who enter go through a set of experiences and exit when they hopefully show improvement. In contrast, SHGs encourage long-term involvement. There are no "graduations" or clear-cut exit points. For example, one never loses one's status as an alcoholic, or as a compulsive gambler or drug addict. Although there are points in many groups of differential status, from beginner to "senior member," it is the nature of SHGs that membership is indeterminate and may

persist far beyond professionally defined recovery. Bereavement groups often produce positive results within 6 months to a year; membership ordinarily lasts far beyond this point in time. It is overly simplistic to see the extended membership as a pathological indicator. In part, the extension of membership on one hand is a payback to others in similar status, in large part it is a fact of the primacy of such groups for affiliation needs, and in part it is a subtle product of the legitimate requirements for such organizations' continued existence. Otherwise, SHGs could not endure, since there would be no one to carry on the work of the organization. The absence of clearly defined exit points makes the study of self-help outcomes less precise than the comparable outcome research in psychotherapy.

Psychotherapy researchers have adopted a shared perspective on whom to measure, since therapy is clearly defined and certain rules have been prescribed regarding participation in therapy. An investigator studying brief psychotherapy, say of 12 sessions, has set standards based on number of sessions for when a person is or is not in therapy. For many participants in self-help, patterns of participation are systematic but differ radically from the weekly or twice-weekly pattern of psychotherapy. It ranges from the not untypical pattern in AA of members going to a variety of different chapters, sometimes three to four times a week, to the systematic use seen in bereavement groups, such as Compassionate Friends, where members sporadically use the group at points of particular stress. They may be active for years, but their pattern of participation is not regular. Further complicating the assessment of outcomes are the findings by Lieberman and Borman (1979) of the multiple use of helping resources by most participants in self-help. They found that 54 percent of the women in consciousness-raising groups were

currently or recently in psychotherapy, 28 percent of the widows/widowers in SHGs were also in psychotherapy for problems associated with spousal loss, and 31 percent of parents who had lost children had utilized psychotherapy for similar problems associated with the loss. Such multiple use is, of course, not absent in psychotherapy research, but the magnitude of such utilization by self-help participants may preclude the simple isolation of particular impact.

These methodological and design issues should not create in the reader's mind the view that it is not possible to evaluate the impact of SHGs. Rather, it calls attention, on one hand, to the current state of knowledge, and, on the other hand, to the fact that the solutions to good empirical research will, by the very nature of the phenomena being studied, have to be somewhat different from traditional solutions to psychotherapy outcome research.

The most widely studied SHG is Alcoholics Anonymous. Although this SHG is not geared specifically towards the elderly, it and other widely studied SHGs can provide examples from which one can generalize to the elderly and their potential use of SHGs. Some studies evaluate AA alone (Bohinc & Orenstein, 1950; Henry & Robinson, 1978), while others have examined the contribution of AA as one of several interventions (Rohan, 1970; Tomsovic, 1970; Rossi, 1970; Kish & Hermann, 1971; Oakley & Holden, 1971; McCance & McCance, 1969; Pattison et al., 1968; and Robson, Paulus, & Clarke, 1965). Large-scale studies based on cross sectional surveys are represented by Bailey and Leech (1965), who obtained questionnaire responses from over 1,000 persons; Edwards and associates (1967), who reported on 306 respondents; and the large-scale AA survey of 11,355 respondents. Such cross-sectional findings suggest that at any point in time, from a third to a half have been

sober less than one year. Studies that evaluated AA as one element in the treatment program suggest that alcoholics who attend AA in addition to other treatment modalities do better.

Despite the overall positive findings, method problems of measurement and sampling do not permit a definitive statement about the efficacy of SHGs. The absence of a good sampling frame and a reasonable control group makes the evaluation of AA problematic. The absence of membership lists in AA obviously complicates the researcher's ability to describe a sampling base. (For a detailed critique of the evaluation of AA see Paul E. Bebbington (1976).)

SHGs addressing eating disorders are rapidly expanding; estimates of upwards of half a million members in the U.S. for TOPS (Take Off Pounds Sensibly) have been made. In a series of studies, Stunkard and colleagues (1970) suggested that the effectiveness of TOPS is limited. In contrast, a recent study by Grimsmo and associates (1981), reporting on a large-scale prospective study of over 10,000 people in a Norwegian SHG for weight reduction, found significant and meaningful weight reduction that was retained over four years among participants in the SHG. These contrasting findings eloquently address the oft-repeated caution that SHGs represent a variety of activities, processes, and conditions. Generalizations without the detailed buildup of empirical studies and conceptual analyses, which address not only effectiveness but the link between the processes and effectiveness, remain in the future.

Outcome studies of other than behavioral disorder groups are less plentiful. Much of the research to be discussed was conducted by Lieberman

and colleagues who have, over the past 7 years, examined eight different SHGs: women's consciousness-raising groups; Mended Hearts (a medical SHG concerned with individuals who have had open-heart surgery); NAIM and THEOS, both SHGs directed toward widows/widowers; Compassionate Friends, a SHG for parents who have suffered the death of a child; Mothers Groups and Mothers of Twins Groups, both SHGs directed towards addressing the emotional problems of motherhood; and SAGE, directed towards those over 65. A variety of methods have been used in the series of studies, including ethnographic observation, intensive interviews, and large-scale panel surveys of members and nonmembers (total N=5,000). The survey questionnaires generate information about who joins, the pathways by which people enter such organizations, alternative help-seeking behavior, how members use the SHGs and a variety of outcome instruments assessing indices of mental and physical health role of functioning, coping strategies, and "affliction" or illness attitudes and beliefs. A follow-up strategy was utilized whereby members and controls were assessed for a minimum of two points in time separated by a year. In the bereavement groups, a long-term follow-up of four years was also conducted.

The research strategy used in these studies resembles the standard outcome designs applied in traditional intervention studies of psychotherapy. The results of this research are encouraging; measurable improvement was found in levels of depression and self-esteem in women who joined consciousness-raising groups; the spousally bereaved who participated in the SHG, compared to controls, showed a marked improvement in levels of depression, well-being, self-esteem, and life satisfaction; among the members of Mended Hearts, the large subgroup who had retired as a consequence of surgery showed significantly improved scores on mental health indicators; among parents who

had lost children, improvement was found, again compared to a control group, in coping strategies and in measures of existential concerns. However, after one-year participation, significant improvement in mental health or social functioning was not found. The results for first-time mothers were more ambiguous, and no substantial data was found to indicate that participation in such groups substantially improved women's psychological or social functioning. Mothers of twins, however, showed some improvement in their social and psychological functioning.

PROCESSES

For over 30 years, psychotherapy researchers have studied and theorized about the transactions associated with patient change. A number of events and experiences are thought to be directly associated with such change. One recent statement of this approach stems from the work of Yalom (1975) and Lieberman, Yalom and Miles (1973). Both studies collated and collected a variety of "curative mechanisms" -- specific experiences that were central in effecting changes in group therapy patients and encounter group participants. Such an approach is frankly phenomenological; it views change induction groups through the eyes of the participants by asking them to recall specific experiences they believe proved to be helpful. Although there has been no dearth of speculation on how SHGs function (Dean, 1971; Gartner & Riesman, 1977; Hurvitz, 1974; Katz, 1970; Robinson & Henry, 1977; Trice & Roman, 1970), much of this literature is anecdotal. Two series of studies, one conducted by Levy and associates (Levy, 1976; 1979), the other conducted by Lieberman and associates (Lieberman & Borman, 1979; Lieberman, 1983) represent formal studies of SHG processes. Both researchers have utilized comparative

strategies contrasting a variety of different self-help and other change-induction groups in their attempt to isolate specific mechanisms.

Lieberman (in Lieberman & Borman, 1979, pp. 194-233) compared the responses to a change mechanism questionnaire of several thousand people who participated in a variety of groups. Respondents were asked to rate, on a 5-point scale, how helpful certain events or experiences were that may have occurred in the groups. The items included both the standard dimensions developed by Yalom (1975) and Lieberman, Yalom, and Miles (1973). In addition, in order to take cognizance of the special circumstances that might be possible in SHGs, other mechanisms were altruism, group cohesiveness, universality, interpersonal learning, guidance, catharsis, identification, family reenactment, self-understanding, installation of hope, existential factors, feedback, and a variety of cognitive restructuring items. Comparisons were made between patients in group therapy, participants in encounter groups, members of mothers' groups, widows, Women's Consciousness-Raising, Compassionate Friends, and Mended Hearts groups.

Use of a comparative framework showed that all types of helping groups are unified by the simple fact that all are collections of fellow sufferers in high states of personal need and that all groups require some aspect of the personal and often painful affliction to be shared in public. Uniformly, participants, in no matter what kind of group, indicated that the ability of such groups to provide for normalization (universalization) and support were central. Despite these common elements, examination of each of the systems studied suggests major differences in emphasis on a variety of other mechanisms. SHGs differ considerably with regard, for example, to their

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emphasis on cognitive mechanisms. Such processes as increasing understanding, putting roles into perspective, and providing insight into personal problems are critical in women's consciousness-raising groups. In contrast, Compassionate Friends participants emphasize the inculcation of hope and existential concerns -- they see cognitive mechanisms as relatively unimportant. Mended Hearts emphasizes altruism, apparently in response to survivor guilt themes in those who have had open-heart surgery. Overall, our findings suggest that despite a common core in all group settings, whether they be self-help or professionally conducted groups, there are major differences in the mechanisms that the participants find useful. Professional groups differ more from SHGs than do the SHGs among themselves. Such an observation would suggest that the simple extrapolation of principles of group psychotherapy to SHGs would be a serious conceptual as well as clinical error.

In a subsequent study, Lieberman (1983) examined the relationship between change mechanisms and positive outcomes in two types of bereavement groups -- THEOS and Compassionate Friends. This examination indicates that the particular change mechanism correlated with outcomes measured by levels of grief and loss intensity were different in the two types of groups. Levy's (1976) work compared a smaller sample of groups (8 chapters in all), which included Take Off Pounds Sensibly, Parents Anonymous, and Make Today Count. The mechanisms studied overlap, to some extent, those previously examined in Lieberman's work, but also include behavioral prescriptions, behavioral proscriptions, behavioral rehearsals, positive reinforcement, punishment, extinction, modeling, reassurance of competence, justification, and personal goal setting. Levy's (1976) list of mechanisms was developed from his observations of these groups rather than the conceptual framework borrowed

from psychotherapy literature.

Levy (1976) concluded that there was more similarity among SHGs than did the previous investigators. He found that the common core across all groups was emphasis on empathy, mutual affirmation, explanation, sharing, morale building, self-disclosure, positive reinforcement, personal goal-setting, and catharsis. Based upon correlations among groups, Levy (1976) found that 43 percent of the variance was accounted for by the common mechanisms.

These two series of studies serve to illustrate the current state of knowledge, clearly just at a beginning. Required are studies that link processes to effectiveness in order to answer the question of whether mechanisms in SHGs are common across groups or, on the other hand, are specific to particular types of groups. Method problems are major in this kind of research, since in the study by Lieberman (1983), the perceptions by participants of what mechanisms were helpful, whether they be professionally conducted groups or SHGs, can to some extent be accounted for by the presence or absence of professional leadership, the ideology of the group, and the nature of the affliction. Participants' perceptions of mechanisms are to some extent influenced not by their own specific experiences, but by the context.

A different framework for understanding processes is offered by Paul Antze (in Lieberman & Borman, 1979, pp. 272-304), who emphasizes the persuasive function of SHGs. Antze theorizes that some of the special characteristics of such groups lead to their high persuasiveness. High persuasiveness is linked to Antze's view that SHGs are fixed communities of belief in which the sharing of an experience by the stories that members tell

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becomes an object lesson and a means of indoctrination. The members' frequent attempts to persuade newcomers acts to reinforce their own convictions. Furthermore, the common affliction makes for a high cohesiveness and easy mutual identification. Finally, the fact that many SHGs contain individuals who have problems of an extreme and terrifying kind suggests that many enter such groups in a state of despair that makes them more prone to influence. Antze suggests that these characteristics are well adapted to inducing standardized changes of outlook at a deep level among the members of SHGs, and it is these processes that are identified collectively by the group's ideology.

Furthermore, Antze (in Lieberman & Borman, 1979) suggests that each group analyzed (AA, Recovery Inc., and Synanon) has a specific ideology that is closely linked to the underlying psychological problem associated with the affliction. For example, his analysis of AA suggests that the common pathology found among alcoholics reflects an exaggerated sense of personal agony and that this attitude plays a central role in the psychology of compulsive drinking. His analysis of the AA ideology suggests that it is a specific and thorough antidote to this way of being; its prime therapeutic function is to induce a wide range of contradiction in a member's sense of agency. To absorb the AA message is to see oneself much less the author of events in life, the active fighter and doer, and much more as a person with the wisdom to accept limitations and wait for things to come. Antze's (in Lieberman & Borman, 1979) careful analysis of AA and comparison to Recovery, Inc., which on superficial grounds may seem to function similarly, suggests that this framework is a useful one for looking at the specific and often unique characteristics of each particular SHG.

Lieberman and colleagues suggest another perspective on SHG change-inducing processes. They analyze the SHG from the point of view of social support and social network theory. SHGs emphasize strong identification among people with similar problems, a situation which often leads to the creation of strong new social ties. For example, widows who formed social networks for helping one another emotionally outside of the formal group meeting were those who profited by their participation in the SHG. Those who did not showed less change. All three perspectives suggest that the processes by which SHGs work may be different from those found in professionally conducted therapy.

In summarizing these views on process, it might be useful to contrast SHGs to professionally conducted therapeutic groups. An examination would reveal that there are several important distinctions worthy of attention. The psychological distance between members and leader of a SHG is small when compared to the psychological distance between patients and a group therapist. Despite the modern trend to lessen the psychological distance between professionals and their patients, such as the use of informal setting and therapist transparency, the distance between the therapist and the patient remains.

In professionally conducted group therapy of almost all theoretical persuasions, the group is viewed as a social microcosm -- a small complete social world reflecting in miniature all the dimensions of broader social environments. It is this aspect of the group -- its reflection of the interpersonal issues confronting individuals in the larger society -- that is

most highly prized as the way groups induce change. SHGs do not emphasize analysis of the transaction of members; it is not their basic tool of change.

Another characteristic that appears to distinguish between professional and self-help groups is their emphasis on differentiation among members. The potency of SHGs appears to stem from the continued insistence on the possession of a common problem. Such an emphasis is different from the temporary undifferentiated status of members in early sessions of a psychotherapy group, for it is usually considered a problem requiring work that can lead to differentiation.

Lieberman and Bliwise's (1985) study illustrates the consequences of such distinctions. SAGE (Senior Actualization and Growth Explorations) is a group program developed initially by professionals for the well elderly. In an earlier study, Lieberman and Gourash (1979) found SAGE to be effective. Over the years, the program developed into a SHG. The 1985 study, based upon the randomization into professionally led groups and those led by the elderly using SAGE techniques, suggested that the SHGs using the SAGE procedures were less successful than those conducted by professionals.

This study illustrates the limits of using transfer of technology as a means for professionals to aid the development of SHGs. It also illustrates the distinction between the vast majority of SHGs in which helping methods grow out of a particularistic view of the affliction and are usually the product of a long series of "empirical trials" codified into an ideology. This distinction is salient for SHGs among the elderly and their caregivers. It is the authors' impression that the label "self-help" has often been

applied to activities that are professionally structured, utilizing populations with similar problems or afflictions. Less frequently encountered are SHGs that have developed their processes by the afflicted themselves. It is not a distinction between professional involvement and total absence of professionals in SHGs. The critical test is on the origin of the helping model.

These conceptual distinctions underscore some of the problems found in much of the current empirical research on SHGs. The adequate study of such groups is unlikely to occur if there is a simple translation of the extensive group therapy research model. The status of current SHG research is perhaps akin to that of group therapy research when it began to emerge as a separate entity in the early 1960s. The early research was characterized by an emphasis on translating conceptual, as well as empirical, principles from individual psychotherapy, which many researchers believe led to serious errors and false leads in group psychotherapy research.

POLICY IMPLICATIONS AND RECOMMENDATIONS

SHGs are often erroneously believed to be anti-professional. A careful study reported in Lieberman and Borman (1979) indicated not only that professionals have been involved in founding and supporting many SHGs, but also that most participants utilize professional help to a greater extent than do nonmembers of SHGs. In a number of specific instances, such as women's consciousness-raising groups, bereavement groups, and health groups, participants indicate fairly high satisfaction in their experience with psychiatric services. A review of ten major SHGs (Alcoholics Anonymous,

Recovery, Inc., Integrity, Mended Hearts, NAIM (bereavement group), Grow, Synanon, Compassionate Friends, Parents Anonymous, and Epilepsy SHG) revealed that in six of the ten, professionals played a key role in founding the organization or in giving it an early major boost and helping shape it (Lieberman & Borman, 1979, pp. 21-24).

What are some of the ways professional mental health service providers can productively relate to SHGs? SHGs should and can be seen as an alternative source for providing help to emotionally distressed members of society. The evidence reviewed in this report suggests that the SHG can, for a wide range of people who have emotional problems, serve as a useful and productive "therapeutic" setting. From the point of view of mental health providers, therefore, SHGs can be seen as a viable alternative referral. As indicated, a number of participants in SHGs are contemporaneously using other mental health services. Synergistic utilization of these two distinct treatment settings would be a positive outcome. The data so far analyzed do not permit such a clear finding to emerge. In one study (Lieberman, Solow, Band, & Reibstein, 1979), the psychotherapeutic impact of women's consciousness-raising groups suggested that such synergistic effects may take place. Other studies of conditions such as bereavement did not produce clear data on synergistic effects.

THE DEVELOPMENT OF SHGS AMONG THE ELDERLY

The most complex issue facing professionals interested in SHGs is finding the approach professionals can use to encourage, generate, develop, and maintain SHGs. As indicated above, professionals can serve a variety of

functions in the development of SHGs, and the ultimate test of whether the services they provide are useful is an empirical one. The technological transfer of professional involvement in self-help is one such function. There are many illustrative cases of professional generation of SHGs. For example, the Duke Alzheimer's caregiver project is a good example of how volunteers and professionals linked together to provide a mechanism for the generation and maintenance of groups. Published data from those projects is currently insufficient to determine the long-range maintenance of such groups once professional stimulation and maintenance is withdrawn.

What enables most SHGs to flourish and maintain themselves over time is a set of ideological precepts. Professionals must be sensitive to their content, which addresses the nature, cause, and cure of afflictions or problems; these may often be diametrically opposed to professional views of the nature of the problem and most particularly the procedures for helping. However, as the data indicate that SHGs are effective, support from formal service institutions is in line. Another profession model that is currently beginning in the State of California is the Self Help Center (UCLA), which involves the use of programmed learning tapes that will aid groups of similar sufferers by providing structure for interacting and group formation.

A common model for generating new SHGs is the use of spin-offs. Well-established groups such as Alcoholics Anonymous are copied by a variety of other groups based on similar afflictions. This approach has had some success, but can become quickly limited. Since the particular ideology, strategy, and structure of AA addresses some of the special psychological issues of alcoholism, they may have little to do with other problems. Groups

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that appear to have been successful in adapting current ideologies and structures have modified the particular views adapted from other SHGs. Some self-help clearinghouses have helped the spread and maintenance of SHGs by providing for consultation from one SHG to another. A study of the history of many SHGs clearly suggests the center role of professionals in many such organizations. The models are many, and those that have been successful recognize the distinction between professional involvement and professional direct service. It is the latter that inhibits the development of SHGs, although such activities obviously may offer important services. Planners need to be clear as to what kind of institutions are needed and not make the all-too-frequent mistake of merely co-opting terms that may have current value (as self-help does) for traditional service delivery.

Self-help groups can be a low-cost, effective resource in serving the mental health needs of the elderly. However, there are special issues, considerations, and concerns warranting attention -- attention that goes beyond the all-too-frequent underutilization of services by the elderly. If underutilization were the sole issue, analyses of the barriers to SHG utilization and the special encouragement of the SHG would suffice. Yet, some of the broader questions regarding the elderly suggest that perhaps such a straightforward answer is not sufficient. Recommendations concerning these questions are necessarily based on incomplete data, due to the dearth of research on SHGs for the elderly. We assume that increased utilization of SHGs by the elderly is a primary goal of policymakers.

In order to recommend steps to increase utilization of SHGs by the elderly, it will be helpful to discuss some hypotheses about their underuse,

given that the factors examined above did not clearly account for the elderly's lack of use.

Legitimization Factors

SHGs, like other service structures, require societal legitimization. This issue may be particularly salient for the elderly because the current elderly are a generation raised with high investment in and respect for traditional sources of help such as physicians and clergy. Thus, they may be hesitant to use the nontraditional SHGs or even to consider them as an option. The usual lack of legitimization of SHGs most likely exacerbates the elderly's attitudes towards SHGs.

Recommendations. Professionals can play a critical role in influencing such attitudes. Health care providers frequently function to transfer legitimization initially granted to them by society to the SHG. Other traditional systems, such as the religious institutions society sanctions for servicing the bereaved, are frequently the prime legitimizers of the bereavement SHG.

Specific government and foundation-funded projects, using social service or hospital affiliation as a base, have attempted to generate and legitimize SHGs among the elderly. For example, a large Duke University project on caregivers to Alzheimer's patients provides legitimization through the well-known reputation of a major university in the area of service to the elderly. A critical function that mental health organizations can play in assisting SHGs is simply to provide legitimization. Such legitimization may

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alleviate some of the doubts the elderly have about the SHG as a viable source of help.

Age-Homogeneous vs. Age-Heterogeneous Groups

Homogeneity of affliction, problem, or issue facing the participants is of paramount importance in SHGs. What is required is a perceived similarity based upon disease or affliction, status, crisis, or life transition. Age alone does not appear to be a valid form of homogeneous composition, and it is unlikely, excepting SHGs organized for externally oriented changes (political action), that the focus of the SHG for mutual aid and self-improvement could be organized around age alone. However, groups focused on retirement, unemployment, grandparents of the divorced, and other issues can be salient for the elderly. Whether the elderly would do better in age-heterogeneous groups, once the basis of identification regarding affliction were managed, is a question for which only speculative responses are possible. There are valid sociological and psychological bases for making an age-homogeneous argument. It is important to underscore that psychologically salient, mutual, and instant identification must be present.

Recommendations. Development and encouragement of age-homogeneous SHGs for the elderly may be more attractive to some of the elderly, and thereby increase utilization. Developing such groups may also help to identify areas in which major numbers of the elderly have problems or common concerns but for which there are no groups.

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Access Factors

There are logistical factors affecting the elderly's access to SHGs which may directly contribute to their absence. Time of meetings, especially if in the evenings, may be inconvenient for the elderly. Many older people will not attend functions in the evenings due to fear of crime or reluctance to negotiate unknown areas after dark. This can be exacerbated by the location of the meetings -- if located in a less safe area of a city, or if there is no set location, but meetings change from week to week, perhaps being held at members' homes. For some elderly who would attend SHGs if they could, lack of transportation precludes attendance. Some elderly do not have their own transportation and are reluctant to use public transport after dark or to unfamiliar places.

Recommendations. Formal services could provide places for SHGs to meet, in an accessible, safe place, encouraging daytime meetings. Assistance in and encouragement of organizing ridesharing may alleviate some of the elderly's reluctance. Innovative strategies that are currently being tested should be given high priority. For example, phone networks of Alzheimer's caretakers is a recent innovative project just underway.

DEMONSTRATION PROJECTS FOR ENCOURAGING SELF HELP GROUPS FOR THE ELDERLY

Beginning in 1978, the Administration on Aging funded at least 7 demonstration projects to encourage the development of self-help group services for the elderly. Unfortunately no overall project report is available. Our research group interviewed the principle investigators of each

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of the projects we could locate. The projects were wide ranging; but generally involved some form of training peer facilitators. For example the University of Louisville's Gerontological Center facilitated 8 self-help groups dealing with topics in legal areas, social security, medical and political issues. The Turner Geriatric Clinic, University of Michigan Hospital, organized self-help groups using peer counselors working with elderly physically ill on an outpatient basis. The groups are organized around problem areas -- cancer support, care for the aging parents, divorce after 60, hearing and vision problems, and so forth. No formal evaluation is available. This project reached several thousand people and was apparently able to develop some ongoing groups although many were short term. A somewhat different strategy was used by the Chicago Senior Citizens Self-Help Project which organized groups run by volunteers as a service to others -- visiting house bound elderly, escort services, home delivered meals and so forth.

The general impression by all of the principle investigators we were able to contact is that the services were "successful", but by and large they did not endure beyond the limits of the demonstration project.

The absence of any evaluation data unfortunately vitiates the utility of these demonstration projects. Without some overriding conceptual framework that would guide both the kind of demonstration project and how it is conducted as well as who it serves, little useful information can be gained from the efforts.

Finally, professionals have been and are currently involved in a variety of new structures in our society associated with SHGs -- self-help centers and

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clearinghouses. These are professionally run organizations that provide many of the support and consultative help to SHGs. Several are involved in large scale programs helping to establish through a variety of ways new SHG. It is through these that professionals frequently can provide an inestimable service to SHGs without the dangers of turning such groups into simple extensions of professional help. Critical is our understanding that each SHG develops a set of ideological percepts and we must be sensitive to their content since they address the nature, cause, and cure of affliction or problems and often may be diametrically opposed to a psychiatric view of the nature of the problems and most particularly to the procedures of helping. Turning SHGs into inadequately trained mental health professionals is not useful or appropriate.

RESEARCH AGENDA

A review of the empirical research currently available on self-help groups, and particularly those studies that specifically address the elderly, clearly point to the need for information that could illuminate appropriate strategies and policy choices relevant to self-help groups. What is required is a major research effort to answer, in a 3 to 5 year time frame, a series of questions necessary for potentiating the contribution of self-help groups to the well-being of the elderly. Such an effort would clearly go beyond the limits of any single group of researchers, and, yet, to be maximally successful, would require some mechanisms for linking researchers so that there was a reasonable chance that the information generated would be summative.

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THE OUTCOME QUESTION

As the preceding review clearly indicates, although adequate outcome information is not available, the limited information on non-elderly participants in self-help groups is highly encouraging. The start for any evaluation of the effectiveness of self-help groups to address the problems of mental illness and distress in the elderly should begin with a series of studies examining current standard self-help organizations to determine the effectiveness of their helping strategies in these age-heterogeneous groups of elderly. A series of studies directed towards a sampling of common problem groups that contain numbers of elderly persons with the various typologies of self-help groups could provide, within two years, clear cut data on the level of contribution to the mental health and lowering of mental distress in elderly populations.

Beyond this step, the more complex question of what problems, for whom and at what point in time such treatment settings as self-help groups can contribute would be an important and perhaps critical followup of the simple outcome studies. Such research would determine what the current service system, defined as the collectivity of self-help groups, could contribute to the elderly if we were not to alter in any way the current systems, excepting to devise strategies for increasing the participation of the elderly. Such research could not of course tell us how we could maximize effectiveness of self-help groups for the elderly.

The next research priority would be to determine methods for maximizing the potential of self-help groups to contribute to the mental health and

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mental well-being of the elderly. The likely candidate here is the development of age-homogeneous self-help groups that would cover the same problem areas that currently are addressed in the standard self-help organizations which are age-heterogeneous. The success of this "experiment" would lead to a policy of encouraging the development of self-help groups that are age-homogeneous as well as problem-homogeneous. It is likely that if age-homogeneity provided a significant increment in facilitating the impact for the elderly, current self-help organizations could be encouraged to utilize their networks to aid in developing such groups.

A third research priority would be directed towards generating information on how to expand the number of elderly participants in self-help groups. Research directed toward an analysis of the possible attitudes and other factors that lead to the elderly's under-utilization should be conducted. In addition, analyses of current self-help group practices which may present barriers to the entrance of the elderly into them are required. Beyond these static analytic strategies, critical pilot demonstration projects -- of the kind outlined in the present review -- would facilitate strategy and policy decisions regarding self-help and the elderly. Here the complex role of professionals in relationship to current volunteer organizations and utilization of new technologies such as the one begun at the UCLA Self-Help Center should be explored. Such demonstration/research projects could articulate the payoff of various strategies for generating new self-help groups as well as self-help groups in geographical areas where none exist. Clearly such investigations would have to be tied to the impact or outcome, so that accumulative data using both information generated from studying the elderly in current self-help groups, in self-help groups that are

age-homogeneous and these new forms of self-help generated by alternate strategies could be compared.

A fourth priority would be to develop studies that would elucidate the unique processes that characterize productive self-help groups. As indicated in this review, there are several major viewpoints on the characteristics of self-help groups that make them profitable to their participants. Some of the models resemble those of psychotherapy, others are quite distinct from professionally applied services. Studies that would enable a careful look at the processes or characterizations that have produced benefits in self-help groups would not only be a contribution in general to the social sciences, but would enable future development of more effective self-help groups or self-help groups for problem areas not represented by those available today. An understanding of the necessary process-outcome linkage could provide a major emphasis for these new developments or new technologies such as the generation of self-help groups through audio-tape-led programs.

And, finally, as is clear from what has been already presented in the review of current knowledge on self-help groups, they are not professional systems both in who they serve and how they serve them. Critical for the integration of various services to the mentally disturbed and distressed elderly is examination of the kinds and types of ties, linkages and relationships which self-help groups, as fundamentally volunteer organizations, should have to professional services and professionals. We know very little about this area, an occasional clinical paper or case report has been published in the literature suggesting some of the negative consequences of inadequate or inappropriate relationships between professional

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agencies and self-help groups. Other published reports suggest that professionals have played an essential role in the origins of many self-help groups. The linkage between professional services and voluntary organizations is an area that requires careful policy and evaluation research. Simple questions such as what is the appropriate role of financial support from government sources for self-help groups do not yield simple answers. There are some illustrations that large funding would rapidly convert what is currently a voluntary organization into a quasi-professional one. In some problem areas this may be appropriate; in others it may be highly destructive. Issues such as these require systematic assessment.

IMPLICATIONS FOR HEALTH PROFESSIONALS

What little published data is available indicates that most health and mental health professionals know little of self-help groups beyond Alcoholic's Anonymous. Certain groups have reached certain health professionals -- for example Mended Hearts, a group for those who have had open heart surgery, have established linkages with a number of specific surgeons and cardiologists across the country. However, general education for all health professionals about the role function and availability of this alternate service system is imperative. Clearly what is required is an education which describes these systems, what we know about their effectiveness and how to relate to them as a source of referral.

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TABLE 1

ASSOCIATION BETWEEN TYPE OF SELF-HELP
GROUP AND PROFESSIONAL PSYCHOTHERAPIES AND AGE
(weighted n)

Type of Self- Help Group	Count	18-24	25-34	35-49	50-64	65-79	ROW
	Row PCT COL PCT	1.	2.	3.	4.	5.	TOTAL
Behavioral	1.	11	211	251	248	38	760
		1.5	27.8	33.1	32.6	5.0	2.4
		0.2	2.9	3.6	3.5	0.9	
Support	2.	40	114	120	15	0	289
		13.8	39.5	41.5	5.1	0.0	0.9
		0.7	1.6	1.7	0.2	0.0	
Growth	3.	246	240	149	143	31	808
		30.4	29.7	18.4	17.7	3.8	2.6
		4.3	3.3	2.1	2.0	0.7	
Other Therapy	4.	829	977	783	787	339	3715
		22.3	26.3	21.1	21.2	9.1	11.8
		14.6	13.3	11.2	11.0	7.7	
No Therapy	5.	4537	5811	5714	5965	4010	26037
		17.4	22.3	21.9	22.9	15.4	82.4
		80.1	79.0	81.4	83.3	90.8	
Column		5663	7354	7016	7158	4418	31609
Total		17.9	23.3	22.2	22.6	14.0	100.0

TABLE 2

ASSOCIATION BETWEEN INSTRUMENTAL SUPPORT AND AGE

Social Support	Count		18-24 1.	25-34 2.	35-49 3.	50-64 4.	65-79 5.	ROW TOTAL
	Row PCT	COL PCT						
Yes 1	1.		1469	2114	1806	2453	1837	9679
			15.2	21.8	18.7	25.3	19.0	30.6
			25.9	28.7	25.7	34.3	41.6	
Yes 2	2.		2634	2931	2948	2973	1834	13321
			19.8	22.0	22.1	22.3	13.8	42.1
			46.5	39.9	42.0	41.5	41.5	
Yes 3	3.		914	1383	1314	1122	428	5162
			17.7	26.8	25.5	21.7	8.3	16.3
			16.1	18.8	18.7	15.7	9.7	
Yes 4	4.		566	589	543	259	65	2022
			28.0	29.1	26.9	12.8	3.2	6.4
			10.0	8.0	7.7	3.6	1.5	
Yes 5	5.		34	143	91	61	7	336
			10.2	42.5	27.2	18.0	2.0	1.2
			0.6	1.9	1.3	0.8	0.2	
Yes 6	6.		0	17	57	0	0	74
			0.0	23.1	76.9	0.0	0.0	0.2
			0.0	0.2	0.8	0.0	0.0	
No	7.		46	177	257	289	247	1016
			4.5	17.4	25.3	28.5	24.3	3.2
			0.8	2.4	3.7	4.0	5.6	
Column			5663	7354	7017	7158	4418	31610
Total			17.9	23.3	22.2	22.6	14.0	100.0

TABLE 3

ASSOCIATION BETWEEN LEVEL OF INSTRUMENTAL SUPPORT
AND TYPE OF SELF-HELP GROUP AND PROFESSIONAL PSYCHOTHERAPIES

Social Support	Count Row PCT COL PCT	Self-Help Behav. 1.	Support 2.	Growth 3.	Other Therapy 4.	No Therapy 5.	ROW TOTAL
Yes 1	1.	193	11	168	1204	8101	9678
		2.0	0.1	1.7	12.4	83.7	30.6
		25.4	4.0	20.8	32.4	31.1	
Yes 2	2.	382	106	422	1531	10879	13320
		2.9	0.8	3.2	11.5	81.7	42.1
		50.2	36.8	52.2	41.2	41.8	
Yes 3	3.	128	63	137	539	4294	5162
		2.5	1.2	2.7	10.4	83.2	16.3
		16.8	21.7	17.0	14.5	16.5	
Yes 4	4.	40	69	63	230	1620	2022
		2.0	3.4	3.1	11.4	80.2	6.4
		5.3	23.7	7.8	6.2	6.2	
Yes 5	5.	11	0	0	29	296	336
		3.4	0.0	0.0	8.5	88.1	1.1
		1.5	0.0	0.0	0.8	1.1	
Yes 6	6.	0	0	0	29	46	74
		0.0	0.0	0.0	38.5	61.5	0.2
		0.0	0.0	0.0	0.8	0.2	
No	7.	6	40	18	153	799	1016
		0.6	3.9	1.8	15.1	78.6	3.2
		0.8	13.8	2.3	4.1	3.1	
Column		760	289	808	3715	26036	31608
Total		2.4	0.9	2.6	11.8	82.4	100.0

TABLE 4

ASSOCIATION BETWEEN EMOTIONAL SUPPORT AND AGE

Emotional Support	Count		18-24	25-34	35-49	50-64	65-79	ROW TOTAL
	Row PCT	COL PCT						
			1.	2.	3.	4.	5.	
Yes 1	1.		2291	3034	3120	3096	2135	13676
			16.8	22.2	22.8	22.6	15.6	43.3
			40.5	41.3	44.5	43.2	48.3	
Yes 2	2.		1886	2280	2131	2275	1265	9837
			19.2	23.2	21.7	23.1	12.9	31.1
			33.3	31.0	30.4	31.8	28.6	
Yes 3	3.		977	1263	794	619	274	3928
			24.9	32.2	20.2	15.8	7.0	12.4
			17.3	17.2	11.3	8.7	6.2	
Yes 4	4.		234	297	251	134	34	951
			24.6	31.3	26.4	14.1	3.6	3.0
			4.1	4.0	3.6	1.9	0.8	
Yes 5	5.		34	109	29	80	3	255
			13.5	42.6	11.2	31.4	1.3	0.5
			0.6	1.5	0.4	1.1	0.1	
Yes 6	6.		0	11	69	0	0	80
			0.0	14.3	85.7	0.0	0.0	0.3
			0.0	0.2	1.0	0.0	0.0	
No	7.		240	360	623	954	706	2883
			8.3	12.5	21.6	33.1	24.5	9.1
			4.2	4.9	8.9	13.3	16.0	
Column			5663	7354	7017	7158	4418	31610
Total			17.9	23.3	22.2	22.6	14.0	100.0

TABLE 5

ASSOCIATION BETWEEN LEVEL OF EMOTIONAL SUPPORT
AND TYPE OF SELF-HELP GROUP AND PROFESSIONAL PSYCHOTHERAPIES

Emotional Support	Count Row PCT COL PCT	Behav. 1.	Support 2.	Growth 3.	Other Therapy 4.	No Therapy 5.	ROW TOTAL
Yes 1	1.	288	120	296	1588	11383	13675
		2.1	0.9	2.2	11.6	83.2	43.3
		37.9	41.5	36.6	42.8	43.7	
Yes 2	2.	267	72	319	991	8187	9836
		2.7	0.7	3.2	10.1	83.2	31.1
		35.2	24.9	39.5	26.7	31.4	
Yes 3	3.	105	69	122	477	3155	3928
		2.7	1.7	3.1	12.1	80.3	12.4
		13.8	23.7	15.1	12.8	12.1	
Yes 4	4.	29	11	41	97	773	951
		3.0	1.2	4.3	10.2	81.2	3.0
		3.8	4.0	5.1	2.6	3.0	
Yes 5	5.	0	0	0	23	232	255
		0.0	0.0	0.0	9.0	91.0	0.8
		0.0	0.0	0.0	0.6	0.9	
Yes 6	6.	0	0	0	40	40	80
		0.0	0.0	0.0	50.0	50.0	0.3
		0.0	0.0	0.0	1.1	0.2	
No	7.	71	17	30	499	2266	2883
		2.5	0.6	1.0	17.3	78.6	9.1
		9.3	5.9	3.7	13.4	8.7	
Column		760	289	808	3715	26036	31608
Total		2.4	0.9	2.6	11.8	82.4	100.0

TABLE 6

ASSOCIATION BETWEEN NUMBER OF HEALTH PROBLEMS AND AGE

Number of Health Problems	Count		18-24 1.	25-34 2.	35-49 3.	50-64 4.	65-79 5.	ROW TOTAL
	Row PCT	COL PCT						
0	0.		3034	3291	2811	2103	682	11921
			25.5	27.6	23.6	17.6	5.7	37.7
			53.6	44.8	40.1	29.4	15.4	
1	1.		1503	2314	2331	2176	1285	9609
			15.6	24.1	24.3	22.6	13.4	30.4
			26.5	31.5	33.2	30.4	29.1	
2	2.		674	1023	1069	1410	1032	5207
			12.9	19.6	20.5	27.1	19.8	16.5
			11.9	13.9	15.2	19.7	23.4	
3	3.		280	463	503	786	689	2721
			10.3	17.0	18.5	28.9	25.3	8.6
			4.9	6.3	7.2	11.0	15.6	
4+	4.		171	263	303	683	730	2151
			8.0	12.2	14.1	31.8	33.9	6.8
			3.0	3.6	4.3	9.5	16.5	
Column			5663	7354	7017	7158	4418	31610
Total			17.9	23.3	22.2	22.6	14.0	100.0

TABLE 7

ASSOCIATION BETWEEN NUMBER OF HEALTH PROBLEMS AND
SELF-HELP GROUPS AND PROFESSIONAL PSYCHOTHERAPIES

Number of Health Problems	Count Row PCT COL PCT	Self-Help Behav. 1.	Support 2.	Growth 3.	Other Therapy 4.	No Therapy 5.	ROW TOTAL
0	0.	205 1.7 26.9	55 0.5 19.0	323 2.7 40.0	720 6.0 19.4	10618 89.1 40.8	11920 37.7
1	1.	259 2.7 34.1	177 1.8 61.3	238 2.5 29.4	983 10.2 26.5	7952 82.8 30.5	9609 30.4
2	2.	150 2.9 19.7	46 0.9 15.8	112 2.2 13.9	847 16.3 22.8	4053 77.8 15.6	5207 16.5
3	3.	99 3.7 13.1	11 0.4 4.0	65 2.4 8.1	571 21.0 15.4	1973 72.5 7.6	2721 8.6
4+	4.	47 2.2 6.2	0 0.0 0.0	70 3.2 8.6	594 27.6 16.0	1440 66.9 5.5	2151 6.8
Column Total		760 2.4	289 0.9	808 2.6	3715 11.8	26036 82.4	31608 100.0

TABLE 8

ASSOCIATION BETWEEN NUMBER OF STRESS SYMPTOMS AND AGE

Number of Stress Symptoms	Count		18-24 1.	25-34 2.	35-49 3.	50-64 4.	65-79 5.	ROW TOTAL
	Row PCT							
	COL PCT							
0	0.	817	1337	2034	2464	1937	8589	
		9.5	15.6	23.7	28.7	22.5	27.2	
		14.4	18.2	29.0	34.4	43.8		
1-2	1.	2017	2468	2588	2642	1741	11457	
		17.6	21.5	22.6	23.1	15.2	36.2	
		35.6	33.6	36.9	36.9	39.4		
3-4	2.	1217	1423	1137	1216	538	5531	
		22.0	25.7	20.6	22.0	9.7	17.5	
		21.5	19.3	16.2	17.0	12.2		
5-25	3.	1611	2126	1257	837	202	6033	
		26.7	35.2	20.8	13.9	3.4	19.1	
		28.5	28.9	17.9	11.7	4.6		
Column		5663	7354	7017	7158	4418	31610	
Total		17.9	23.3	22.2	22.6	14.0	100.0	

TABLE 9

ASSOCIATION BETWEEN NUMBER OF STRESS SYMPTOMS AND
TYPE OF SELF-HELP GROUP AND PROFESSIONAL PSYCHOTHERAPIES

Number of Stress Symptoms	Count Row PCT COL PCT	Self-Help Behav. 1.	Support 2.	Growth 3.	Other Therapy 4.	No Therapy 5.	ROW TOTAL
0	0.	175	49	23	513	7828	8588
		2.0	0.6	0.3	6.0	91.2	27.2
		23.0	17.0	2.8	13.8	30.1	
1-2	1.	234	91	247	1275	9608	11456
		2.0	0.8	2.2	11.1	83.9	36.2
		30.8	31.6	30.6	34.3	36.9	
3-4	2.	134	46	194	663	4494	5531
		2.4	0.8	3.5	12.0	81.3	17.5
		17.6	15.8	24.0	17.8	17.3	
5-25	3.	217	103	344	1264	4105	6033
		3.6	1.7	5.7	21.0	68.0	19.1
		28.6	35.6	42.6	34.0	15.8	
Column		760	289	808	3715	26036	31608
Total		2.4	0.9	2.6	11.8	82.4	100.0

TABLE 10

ASSOCIATION BETWEEN LEVELS OF PSYCHIC DISTRESS AND AGE

Psychic Distress	Count	PE-3					ROW TOTAL
	Row PCT COL PCT	18-24 1.	25-34 2.	35-49 3.	50-64 4.	65-79 5.	
Low	0.	2377	3526	3788	3832	2221	15744
		15.1	22.4	24.1	24.3	14.1	49.8
		42.0	47.9	54.0	53.5	50.3	
Low-Medium	1.	1234	1360	1400	1436	1227	6658
		18.5	20.4	21.0	21.6	18.4	21.1
		21.8	18.5	20.0	20.1	27.8	
High-Medium	2.	526	663	451	290	130	2060
		25.5	32.2	21.9	14.1	6.3	6.5
		9.3	9.0	6.4	4.1	2.9	
High	3.	1526	1806	1377	1600	840	7148
		21.3	25.3	19.3	22.4	11.7	22.6
		26.9	24.6	19.6	22.4	19.0	
Column		5663	7354	7017	7158	4418	31610
Total		17.9	23.3	22.2	22.6	14.0	100.0

TABLE 11

ASSOCIATION BETWEEN PSYCHIC DISTRESS
AND SELF-HELP GROUPS AND PROFESSIONAL PSYCHOTHERAPIES

Psychic Distress	Count	Self-Help			Other	No	ROW TOTAL
	Row PCT COL PCT	Behav. 1.	Support 2.	Growth 3.	Therapy 4.	Therapy 5.	
Low	0.	297	106	261	875	14203	15742
		1.9	0.7	1.7	5.6	90.2	49.8
		39.1	36.8	32.2	23.6	54.6	
Low-Medium	1.	194	69	201	851	5342	6657
		2.9	1.0	3.0	12.8	80.2	21.1
		25.6	23.7	24.9	22.9	20.5	
High-Medium	2.	57	6	63	345	1590	2060
		2.8	0.3	3.1	16.7	77.1	6.5
		7.5	2.0	7.8	9.3	6.1	
High	3.	211	109	283	1643	4901	7148
		3.0	1.5	4.0	23.0	68.6	22.6
		27.8	37.5	35.1	44.2	18.8	
Column		760	289	808	3715	26036	31608
Total		2.4	0.9	2.6	11.8	82.4	100.0

TABLE 12

ASSOCIATION BETWEEN ROLE IMPAIRMENT AND AGE

Role Impairment	Count	PE-3					ROW TOTAL
	Row PCT COL PCT	18-24 1.	25-34 2.	35-49 3.	50-64 4.	65-79 5.	
No Impairment	0.	2691 15.7 47.5	3177 18.6 43.2	3520 20.6 50.2	4529 26.5 63.3	3191 18.7 72.2	17108 54.1
Non-Psycho. Impairment	1.	2114 21.1 37.3	2794 28.0 33.0	2371 23.7 38.0	1764 17.6 24.6	953 9.5 21.6	9997 31.6
Low Impairment	2.	223 13.5 3.9	503 30.6 6.8	463 28.1 6.6	375 22.8 5.2	82 5.0 1.9	1646 5.2
Medium Impairment	3.	274 28.4 4.8	280 29.0 3.8	234 24.2 3.3	117 12.1 1.6	62 6.4 1.4	967 3.1
Medium Impairment	4.	234 26.2 4.1	303 33.9 4.1	120 13.4 1.7	194 21.8 2.7	41 4.6 0.9	893 2.8
Severe Impairment	5.	126 12.6 2.2	297 29.7 4.0	309 30.9 4.4	179 17.9 2.5	89 8.9 2.0	1000 3.2
Column Total		5663 17.9	7354 23.3	7017 22.2	7158 22.6	4418 14.0	31610 100.0

TABLE 13

ASSOCIATION BETWEEN ROLE IMPAIRMENT
AND SELF-HELP GROUPS AND PROFESSIONAL PSYCHOTHERAPIES

Role Impairment	Count Row PCT COL PCT	Self-Help Behav. 1.	Support 2.	Growth 3.	Other Therapy 4.	No Therapy 5.	ROW TOTAL
No	0.	297	101	242	1345	15121	17106
Impairment		1.7	0.6	1.4	7.9	88.4	54.1
		39.1	34.8	30.0	36.2	58.1	
Nonpsycho.	1.	286	137	457	982	8135	9996
Impairment		2.9	1.4	4.6	9.8	81.4	31.6
		37.6	47.4	56.6	26.4	31.2	
Low	2.	46	11	40	354	1194	1646
Impairment		2.8	0.7	2.4	21.5	72.6	5.2
		6.0	4.0	5.0	9.5	4.6	
Medium	3.	42	23	11	377	513	967
Impairment		4.4	2.4	1.2	39.0	53.1	3.1
		5.6	7.9	1.4	10.2	2.0	
Medium	4.	34	17	17	201	623	893
Impairment		3.8	1.9	1.9	22.5	69.8	2.8
		4.5	5.9	2.1	5.4	2.4	
Severe	5.	55	0	40	456	449	1000
Impairment		5.5	0.0	4.0	45.6	44.9	3.2
		7.2	0.0	5.0	12.3	1.7	
Column		760	289	808	3715	26035	31607
Total		2.4	0.9	2.6	11.8	82.4	100.0

TABLE 14

ASSOCIATION BETWEEN PSYCHIATRIC DIAGNOSIS AND AGE

Psychiatric Diagnosis	Count	PE-3					ROW TOTAL
	Row PCT COL PCT	18-24 1.	25-34 2.	35-49 3.	50-64 4.	65-79 5.	
Major Depression	0.	211	360	343	456	266	1596
		13.2	22.5	21.5	28.6	14.2	5.1
		3.7	4.9	4.9	6.4	5.1	
Agoraphobia	1.	34	46	91	128	75	375
		9.1	12.2	24.4	34.1	20.1	1.2
		0.6	0.6	1.3	1.8	1.7	
Panic Phobia	2.	274	251	69	66	62	722
		38.0	34.8	9.5	9.2	8.5	2.3
		4.8	3.4	1.0	0.9	1.4	
General Anxiety	3.	223	526	331	616	315	2011
		11.1	26.1	16.5	30.6	15.7	6.4
		3.9	7.1	4.7	8.6	7.1	
Other Anxiety	4.	857	874	766	600	281	3378
		25.4	25.9	22.7	17.8	8.3	10.7
		15.1	11.9	10.9	8.4	6.4	
All Others	5.	4063	5297	5417	5292	3459	23526
		17.3	22.5	23.0	22.5	14.7	74.4
		71.7	72.0	77.2	73.9	78.3	
Column		5663	7354	7017	7158	4418	31609
Total		17.9	23.3	22.2	22.6	14.0	100.0

TABLE 15

ASSOCIATION BETWEEN PSYCHIATRIC DIAGNOSIS AND
SELF-HELP GROUPS AND PROFESSIONAL PSYCHOTHERAPIES

Psychiatric Diagnosis	Count Row PCT COL PCT	Behav. 1.	Support 2.	Growth 3.	Other Therapy 4.	No Therapy 5.	ROW TOTAL
Major Depression	0.	38 2.4 5.0	34 2.1 11.9	39 2.4 4.8	567 35.5 15.3	919 57.6 3.5	1596 5.1
Agoraphobia	1.	23 6.1 3.0	0 0.0 0.0	11 3.0 1.4	121 32.3 3.3	219 58.5 0.8	375 1.2
Panic Phobia	2.	11 1.6 1.5	29 4.0 9.9	39 5.4 4.8	75 10.4 2.0	568 78.6 2.2	722 2.3
General Anxiety	3.	49 2.4 6.5	0 0.0 0.0	91 4.5 11.3	443 22.0 11.9	1427 71.0 5.5	2011 6.4
Other Anxieties	4.	107 3.2 14.1	46 1.4 15.8	141 4.2 17.4	618 18.3 16.6	2466 73.0 9.5	3378 10.7
All Others	5.	531 2.3 69.9	181 0.8 62.5	487 2.1 60.3	1890 8.0 50.9	20435 86.9 78.5	23524 74.4
Column Total		760 2.4	289 0.9	808 2.6	3715 11.8	26035 82.4	31607 100.03